TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL MRI AND DIAGNOSTIC

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-15-3664-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The respondent did not submit a position summary.

Amount in Dispute: $5,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the DWC 060, the Requestor billed $5,250.00 for these two MRI procedures, and the DWC060 shows no payment from the carrier. Attached find Explanation of Benefit forms showing a total of $937.76 was paid. We believe this is the correct reimbursement per the DWC guidelines."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2014	CPT Code 73721-RT-59 MRI Lower Extremity	$2,625.00	$49.26
	CPT Code 72148-59 MRI Spine	$2,625.00	$42.80
TOTAL		$5,250.00	$92.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Workers compensation state fee schedule adjustment.
   - Claim/service lacks information which is needed for adjudication.
   - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
   - Modifier 59 was billed indicating a procedure or service was distinct or independent from other services on the same day or a combination of codes that would normally not be billed together on the same day. Documentation describing whether the modifier was used to identify a different session or patient encounter, a different procedure or surgery, a different site, separate lesion, or separate injury (or area of injury in extensive injuries) is required to determine the correct payment of the services.
   - A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated rate.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for MRIs performed on October 29, 2014?

Findings

1. According to the explanation of benefits, the respondent paid for the disputed services based upon a negotiated rate. No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier Insurance Co. of the State of PA and Memorial MRI and Diagnostic prior to the services being rendered; therefore 28 Texas Administrative Code §134.203(c)(1) applies.

2. According to the submitted explanation of benefits, the respondent paid a total of $322.24 for CPT code 73721-RT-59 and $307.97 for CPT code 72148-59.

   To determine if the requestor is due additional reimbursement for CPT codes 73721-RT-59 and 72148-59 the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2014 DWC conversion factor for this service is 55.75.

   The Medicare Conversion Factor is 35.8228.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77055, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

   Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
73721-RT-59	$238.71	$371.50	$322.24	$49.26
72148-59	$225.39	$350.77	$307.97	$42.80

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $92.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $92.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/14/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.